Psychiatrists' Duties in Discharging Sicker and Potentially Violent Inpatients in the Managed Care Era

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Psychiatrists have certain clinical responsibilities and legal duties to patients treated in managed care settings. They include disclosure of all treatment options, the exercise of rights of appeal for any care they believe will materially benefit patients regardless of allocation guidelines or gatekeeper directives, continuance of emergency treatment, and reasonable cooperation with utilization reviewers. An additional duty—to warn and protect endangered third parties—will likely increase as cost-containment measures curtail the length of hospitalization. The author discusses these duties in the context of sicker and potentially violent patients. He cautions psychiatrists to be careful not to prematurely discharge these patients because of pressures from managed care organizations. The policies of such organizations can place psychiatrists and patients in a precarious position by limiting the time and resources for diagnosis and the assessment of the risk of potential violence. These responsibilities and duties often can be turned into clinical opportunities that enhance the therapeutic alliance with patients. (*Psychiatric Services* 49:62–67, 1998)

The treatment of psychiatric inpatients has changed dramatically in the managed care era (1). Most psychiatric units, particularly in general hospitals, have become short-stay acute care settings. Generally, only suicidal, homicidal, or gravely disabled patients with complex major psychiatric disorders pass strict precertification review for hospitalization (2).

Many of these patients have comorbid substance-related disorders. Close scrutiny by utilization reviewers permits only brief hospitalization (3). The hospital administration may exert pressure for early discharge of these patients to maintain length-of-stay statistics within predetermined limits. The purpose of hospitalization is crisis intervention and management to stabilize patients and ensure their safety.

The treatment of these patients is provided by a variety of mental health professionals. Nonetheless, the psychiatrist must often bear the ultimate burden of liability for treatments gone awry (4). Due to cost-containment policies that shorten hospital stays, opportunity to develop a therapeutic alliance with patients is usually limited. The ability to communicate with patients, the psychiatrist's stock-in-trade, is often severely curtailed. All these factors contribute to a greatly increased risk of malpractice suits against psychiatrists that allege premature or negligent discharge of patients who are violent toward themselves or others.

Psychiatrists have certain responsibilities as well as legal duties to patients treated in managed care settings (5,6). They include disclosure of all treatment options, exercise of appeals for patient care that has been denied, provision of emergency and acute treatment regardless of decisions about coverage, cooperation with utilization reviewers, and warning and protecting third parties. In this paper, these duties are discussed in the context of making discharge decisions for sicker and potentially violent inpatients under managed care.

Psychiatrists' duties and responsibilities

Duty to disclose

As part of the psychiatrist's continuing legal and professional duty to a patient to obtain informed consent, full disclosure should be made of all treatment options, even those not covered under the terms of a managed care plan (7). Agitated and violent psychotic patients may not have the capacity to understand treatment options. Typically, families or other substitute health care decision makers need to be informed.

An increasing number of states are enacting laws making "gag rules" illegal. Gag rules, which are sometimes included in managed care organizations' contractual provisions, limit information on treatment options that physicians can provide to patients or prohibit physicians from revealing to patients certain benefit restrictions or financial incentives to limit care. Psychiatrists should not sign managed care contracts that contain limitations on full disclosure to patients.

Gutheil refers to consent obtained under gag rule conditions as "economic informed consent" (Gutheil TG, personal communication, 1996).

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Anticipated limitations on inpatient treatment imposed by managed care should be discussed with the patient early in the admission so that alternative treatment plans can be considered and hasty decisions avoided. For example, if one-to-one 24-hour supervision of an acutely suicidal inpatient is required, the patient or substitute decision maker should be informed that this service may not be covered by managed care. Nevertheless, this emergency intervention may be life saving. If coverage of this service is denied, the patient or family must make separate payment arrangements.

Disclosures about treatment limitations should be made in a clinically supportive manner, particularly with potentially violent patients. Patients can become quite disturbed when psychiatrists speak to them about limitations of coverage. They may perceive the psychiatrist as working for the insurance company, which may have an adverse affect on the doctor-patient relationship. When coverage is denied, psychiatrists must negotiate payments with patients as they did before health insurance for treatment of mental disorders was available.

However, a number of managed care organizations' contracts specifically prohibit the physician from charging patients for unauthorized services. Although courts have not imposed a duty on physicians to disclose limitations on care to patients, professional and clinical concern for the patient necessitates it. Denial of coverage will require a full discussion with the patient of other available options, which is discussed below.

The psychiatrist should obtain the patient's consent or that of an appropriate substitute decision maker to provide information to the managed care organization. Unless the patient is a minor, the subscriber's consent should not be relied on. Even if the patient has signed the insurer's blanket authorization form, the subscriber's consent may be insufficient if the patient no longer possesses decision-making capacity. If the patient is not the subscriber, then the patient's signature may not be on file, which means that no prior consent would exist to release information to the managed care organization.

Because violent patients create much anxiety, fear, and legitimate concern, several individuals, including media reporters and law enforcement personnel, may call for information. The identity of unknown callers who state they are utilization reviewers requesting information about a patient should be independently verified. The caller's name and telephone number should be obtained, and that person's employment and position with the managed care organization should be checked.

A conservative approach that provides the managed care organization just enough information for utilization review purposes is sufficient (8). A patient's violent fantasies and impulses, whether directed at oneself or others, represent highly personal and sensitive information that must be handled with professional tact and discretion. The temptation to exploit such information by emphasizing it (if not exaggerating it) is enormous, especially because disclosing this information may be seen as the only way of obtaining necessary care for the patient (Stribling ES, personal communication, 1996). On the other hand, a patient's violent fantasies may be a strong indication for retaining the patient in the hospital, which would require the clinician's disclosing the existence of such fantasies to the managed care organization. Limitations on confidentiality created by mandatory reporting, particularly the duty to warn and protect endangered third parties or to inform the police, should also be disclosed to patients who are making threats or who were threatening or violent to others just before admission.

Duty to appeal

The American Medical Association's council on ethical and judicial affairs has stated that physicians have an ethical obligation to advocate for any care they believe will materially benefit their patients regardless of any allocation guidelines or gatekeeper directives (7). Psychiatrists must advocate with a managed care organization for patient care they believe is essential or advisable. If the advocacy effort fails, patients should be informed that they have a right to appeal the managed care organization's denial of services that the psychiatrist has documented as medically necessary. It is advisable to record that the patient was so advised. Merely informing the patient may not be sufficient.

In *Sarchett v. Blue Cross of California* (9), the court held that the mere existence of a documented right to appeal denials of coverage by itself was insufficient "once it becomes clear to the insurer that its insured disputes its denial of coverage." The court further stated, "The insurer must instead take affirmative steps to make sure that the insured is informed of his remedial rights." These steps are particularly important if it is evident that a patient does not understand the right of appeal. Also, a patient may have sufficient mental capacity but may lack the stamina to pursue an appeal. Patients should be provided on request with documents explaining their right of appeal as well as reports of consultations that might aid their appeal (10).

Psychiatrists must understand managed care grievance procedures and appeal rights. Guidelines for grievance procedures can usually be found in contracts with the managed care organization and provider manuals. Several states have established mechanisms for making appeals to managed care organizations (11). Psychiatrists who are faced with denial of services for patients who remain at significant risk of violence to themselves or others should vigorously pursue appeal and grievance procedures on behalf of their patients. It is appropriate for the psychiatrist to ask for a reviewer knowledgeable in the management of violent patients. It is also reasonable to request that the reviewer put his or her recommendations in writing, to be placed in the patient's chart.

Spending considerable uncompensated time pursuing appeals with generally low success rates can make the psychiatrist resentful, a feeling that must be controlled. An antagonistic relationship with a managed care organization can impair clinical judgment and disrupt the therapeutic alliance with the patient. Secondarily, psychiatrists should exhaust the appeals process so that they have a defense against subsequent allegations of negligent care and release if patients harm themselves or others. Psychiatrists

cannot credibly complain of substandard care arising from managed care policies if they at the same time meekly fall in line with those policies.

For certain patients, involvement in the appeals process may help bind or channel aggression, providing an incidental but beneficial therapeutic experience. Similarly, in pursuing the appeals process, psychiatrists may find some unanticipated relief from frustration over the limitation of services. The appeals process also can be a powerful alliance builder when the psychiatrist and patient work together in filing an appeal.

If appeals fail, the psychiatrist and hospital may need to continue care without financial reimbursement until the patient can be safely transferred or discharged. Even before it is clear that an appeal has failed, it may be necessary to provide such care. However, once reimbursement for continued hospitalization is denied, the hospital administration may apply considerable pressure to discharge the patient. Psychiatrists must be careful not to abandon their patients under these circumstances. The American Medical Association's council on scientific affairs has developed evidence-based discharge criteria for safe discharge from the hospital (12).

Duty to treat

Physicians are liable for failure to treat their patients within the defined standard of care. Although the delivery of medical care has changed dramatically under managed care, psychiatrists must still provide competent care within this system.

"Medically necessary" is an elusive proprietary term that governs payment decisions under various private and public medical coverage systems (13). It is the treating physician's responsibility to determine what is medically necessary; this responsibility belongs to no other party. The physician must then make decisions in conjunction with the patient or his or her substitute decision maker, who must make final health care choices (14). Managed care organizations generally limit or deny payment for services but not the actual services themselves (15).

In *Wickline v. California* (16), the treating physician, Dr. Polonsky, asked for an extended stay of eight additional days for his patient following surgery for Leriche's syndrome (occlusion of the terminal aorta). The reviewer from Medi-Cal, the insurance provider, granted four days. Mrs. Wickline suffered complications following the premature release, resulting in amputation of her leg. She sued Medi-Cal. The jury ruled in her favor, but a California appellate court suggested that the treating physician was liable, not Medi-Cal. The physician was not a defendant in the case. In his testimony, Dr. Polonsky stated that he believed "that Medi-Cal had the power to tell him, as a treating doctor, when a patient must be discharged from the hospital."

The appellate court noted that third-party payers for health care services can be held liable when appeals for medical care on behalf of patients "are arbitrarily ignored or unreasonably disregarded or overridden. However, the physician who complies without protest with the limitations imposed by a third-party payor when his medical judgment dictates otherwise cannot avoid ultimate responsibility for his patient's care. He cannot point to the health care payor as the liability scapegoat when the consequences of his own determinative medical decision go sour" (16).

Wickline is clearly relevant for psychiatrists. The psychiatrist is responsible for the patient's care and has a duty to advocate for the violence-prone patient as part of that care. If necessary, the psychiatrist should continue to treat the patient even if the managed care organization denies authorization for payment. The duty of the psychiatrist to exercise the best medical judgment on behalf of the patient is not dependent on payment, despite considerable pressure for discharge that may be exerted by the managed care organization or the hospital's utilization reviewer.

In another case of premature release, *Wilson v. Blue Cross of Southern California et al.* (17), a California appeals court did not follow the specific language of *Wickline*. In *Wilson*, a patient was hospitalized at College Hospital in Los Angeles suffering from anorexia, drug dependency, and major depression. The treating psychiatrist determined that the patient required three to four weeks of hospitalization. After ten days, the managed care company's utilization review determined that further hospitalization was unnecessary and refused to pay for continued inpatient treatment. The psychiatrist failed to appeal and discharged the patient. The patient committed suicide three weeks later.

The appellate division of the California appeals court held that third-party payers are not immune from lawsuits in regard to utilization review activities. The court determined that both the insurer and the physician may be subject to liability for harm caused to the patient by premature termination of hospitalization. The panel of judges' suggestion in *Wickline* that the physician alone is principally liable for treatment decisions is explicitly rejected in *Wilson*.

However, psychiatrists cannot take cover behind these decisions. The burden of legal liability cannot be easily shifted to managed care organizations, even by vigorous advocacy for the patient. If the psychiatrist recommends a longer hospital stay for a violent patient than is authorized for payment by the managed care organization, immediate discharge that leads to self-harm or harm to others will likely increase the risk of a malpractice suit. Blaming the managed care organization will not provide a viable defense.

For example, in *Wilson*, the plaintiff's attorney reported that entries in the hospital records by the attending psychiatrist stated that Wilson's discharge was the result of pressure applied by the utilization review firm (18). After the psychiatrist was brought into the lawsuit by Blue Cross, the plaintiff's attorney said his story changed. The psychiatrist testified that the discharge was his own independent clinical decision but that the decision was influenced by the utilization review firm.

In *Muse v. Charter Hospital of Winston-Salem, Inc.* (19), a jury found that a hospital had acted negligently in discharging a suicidal patient when his insurance benefits ran out. The 16-year-old patient committed suicide just over two weeks after discharge. The Muse family was awarded $1 million in compensatory damages and $6 million in punitive damages.

On appeal, the North Carolina court of appeals noted in a majority opinion that "a hospital has a duty to the patient to obey the instructions of a doctor, absent the instructions being obviously negligent or dangerous." In reality, hospitals do place restrictions on physicians' discretionary judgments. The appeals court rejected the defense's argument that the psychiatrist's decision to discharge the patient was a superseding negligent act that exempted hospital liability. Appelbaum (20) provides a comprehensive discussion of this complex case and its questionable precedential value. Nevertheless, the decision affirms the central role of physicians in making health care decisions in the hospital, particularly regarding discharge.

Most managed care organizations and their peer reviewers are relatively immune from legal liability by state and federal law (21). Until now, the risk of suits against managed care companies for the negligent performance of utilization review has been suppressed by the Employee Retirement Income Security Act of 1974 (ERISA) (22). ERISA preempts state laws and prohibits negligence claims in cases involving employer-sponsored health plans. However, in recent cases courts have held that the intent of ERISA was not to abolish the right of individuals to sue for negligence.

Some psychiatrists may sign agreements and contracts with third-party payers that they do not sufficiently understand. Nevertheless, they remain professionally and ethically responsible for providing appropriate clinical care. Psychiatrists should review all practice protocols that managed care companies expect clinicians to follow for conformity with the standard of care. It is prudent to have a lawyer review agreements and contracts before signing.

In *Varol v. Blue Cross–Blue Shield of Michigan* (23), the court ruled that when psychiatrists agree to a program's requirements and criteria, they are obligated to perform according to these contracts. The court rejected an attempt by a group of psychiatrists to void a managed care agreement because of alleged deleterious effects on patient care.

The judge in the *Varol* case observed, "Whether or not the proposed treatment is approved, the physician retains the right and indeed the ethical and legal obligation to provide appropriate treatment to the patient." The judge then derisively paraphrased the psychiatrists' complaint: "Irrespective of any obligation I have to my patients and to my profession, my judgment as to what is in the best interests of my patients will not be determined by the exercise of my medical judgment, but by how much I will be paid for my services. . . . Since I am weak in my resolve to afford proper treatment, Blue Cross–Blue Shield of Michigan's preauthorization program would induce me to breach my ethical and legal duties, and the Court must protect me from my weakness."

Once the psychiatrist recommends a treatment plan to the patient, he or she has a duty to provide the treatment or arrange for a suitable treatment alternative (24). The report of a Hastings Center conference on the impact of the new economics states, "Ethics is not free . . . once a patient is the medical responsibility of a practitioner or institution, he simply cannot be discharged when the financial resources are depleted" (25). All steps taken to resolve the patient's need for treatment after payment has been denied by a managed care organization need to be duly documented in the patient's chart.

In treating the potentially violent inpatient, the psychiatrist has a continuing duty to treat or to transfer the patient to another facility where adequate care is available. Conflicts with managed care organizations usually arise over quality of care due to limitation of services. When services are denied, the psychiatrist must be particularly diligent not to abandon the patient. The psychiatrist and patient may work out a lower fee arrangement, the patient may decide to pay the full fee for continued care out of pocket, or the psychiatrist may provide free care during emergency treatment. Psychiatrists should refer to their managed care contracts concerning the permissibility of billing patients directly. Additional hospital costs will have to be negotiated with the patient.

If the patient's risk for violence remains substantial, the need for continuing treatment may require transfer to a facility for longer-term care. Transfer can be a daunting task. Receiving hospitals, including state facilities, often strongly discourage transfer of violent patients. However, the psychiatrist cannot be expected to provide free care indefinitely. After resolution of the current crisis and the provision of necessary care, the psychiatrist is free to transfer or discharge the patient. The patient or family should be provided with a list of facilities that can continue care in the absence of insurance coverage or full payment (26). Paradoxically, in some instances, self-pay (usually no-pay) patients are hospitalized for longer periods than insured patients. Although they still may fall under the scrutiny of the hospital's utilization review, services cannot be limited or denied.

If a patient cannot be managed on the psychiatric unit and continues to pose a danger to self or others, involuntary hospitalization should be considered when the patient meets civil commitment criteria for mental illness and dangerousness. Involuntary hospitalization is legal only when a less restrictive clinically appropriate setting is not available. Patients should never be involuntarily hospitalized solely because their insurance benefits have run out. The usual candidate for involuntary hospitalization is the psychotic patient who poses a significant risk of violence to self or others and who refuses treatment and signs a formal request for discharge against medical advice.

Involuntary hospitalization is always a clinical intervention. It must never be used as a defensive tactic to avoid malpractice liability or to provide a legal defense against a malpractice claim (25). Psychiatrists can be sued for malicious prosecution, false imprisonment, assault and battery, and civil rights violations if they improperly initiate civil commitment proceedings, although such suits are relatively rare. With highly problematic discharges, most clinicians would likely choose to err on the side of safeguarding life by seeking continued hospitalization than on the side of preserving civil liberties.

Referral of the patient to aftercare placements where there are no real mental health services available may constitute abandonment. Psychiatrists who treat inpatients are aware of the

general unwillingness of the overburdened outpatient mental health system to accept the "safely hospitalized" potentially violent patient. Potentially violent patients who are found to be indigent after admission cannot be summarily "dumped."

Patient dumping is defined "as the denial of or limitation in the provision of medical services to a patient for economic reasons and the referral of that patient elsewhere" (27). This problem increased dramatically in the 1980s because of rapidly rising health costs and efforts to cut health care spending. The denial of essential medical care by hospitals and other health care facilities for strictly economic reasons may lead to allegations of patient abandonment. Legal liability may follow (28).

Duty to cooperate with utilization review

As an ally of the patient and as part of the provision of good clinical care, psychiatrists should cooperate with utilization reviewers' requests for information when they have proper authorization. If faced with unreasonable limitations on treatment for a potentially violent patient, the psychiatrist's anxiety may turn to anger directed at the utilization reviewer. Such reactions are almost always counterproductive, tending to antagonize the reviewer and polarize the provider and reviewer to the possible detriment of the patient.

Careful documentation of a current assessment for risk of violence, an accurate description of the current clinical condition of the patient, and an explanation of why the patient cannot be treated as an outpatient are essential. The clinician, when vigorously appealing a denial, should avoid statements that exaggerate the patient's condition or need for treatment (29). Exaggeration may undermine the credibility of the psychiatrist if it is revealed at a later date in a judicial or other proceeding. Also, if payment is denied, the psychiatrist has a greater obligation to continue treatment. Moreover, if the patient commits suicide or injures someone after discharge, the documented record that a seriously ill patient was prematurely discharged will be prominently displayed in court should a malpractice claim arise.

Careful documentation of the need to continue treatment of a patient who remains potentially violent should avoid "in my opinion" statements. Instead, it should include discreet descriptions substantiating the patient's behaviors, violent fantasies, and threats, as well as other supporting data. Confirming second opinions add persuasiveness and also reduce the risk of a successful malpractice suit. A forensic consultant may be able to bring additional arguments for an extension of coverage. Psychometric tests may provide the "hard data" that further substantiate that a patient is at high risk for impulsive violent behaviors.

When benefits are denied, essential aspects of the management of the potentially violent patient include understanding and following grievance procedures carefully, returning telephone calls from review agencies, and providing documented and solid justification for continued treatment. The psychiatrist can request in writing the basis for any utilization reviewer's decision. All contacts with reviewers should be documented in the medical chart, including the name and phone number of the reviewer, date and time of the conversation, the psychiatrist's treatment recommendations and rationale, and the reviewer's response (30). In the event of a denial, the psychiatrist should request and document the request for a physician-to-physician review or any additional appeals processes undertaken.

Duty to warn and protect

Tarasoff v. Regents of the University of California (31), the landmark case on the clinician's duty to warn and protect third parties at risk of harm from a patient's actions, preceded the managed care era by at least two decades. States' statutes and case law vary on the duty to warn and protect. Some states still hold that disclosure of any confidential information is a violation, while other states use permissive language ("may warn or protect") but do not require action by the clinician. Beck (32) asserts that, in effect, the duty to protect endangered third parties is now a national standard of practice. Yet the policies of a managed care organization can place psychiatrists and patients in a precarious position by limiting the time and resources for the diagnosis and the assessment of the risk of potential violence toward others.

Under general negligence law, no duty exists to control the conduct of third persons to ensure that they do not cause physical harm to others. However, the law states that if a patient is in custody, the doctor has a duty to prevent a patient from harming self or others (33). When the patient is under the "control" of the doctor and the hospital, the standard is how the similarly trained, ordinary practitioner would act (34). If actual practice differs from ordinary practice, liability is imposed for a breach of duty if the breach is the proximate cause of damage.

Although liability has been imposed on psychiatric facilities that had custody of patients who injured others outside the institution after their escape or release, these cases are clearly distinguishable from the factual situation of *Tarasoff* (35). *Tarasoff*-type cases involve psychiatric outpatients. Liability arises from therapists' failure to take measures to warn and protect endangered third persons whom the patient threatens to harm. The legal duty to warn and protect third parties exists only if the danger of physical harm is threatened toward others, not in the case of threats of self-harm (36). However, in cases of negligent release, liability may arise from the allegation that the institution's decision in releasing the patient caused injury to the third party.

Although the *Tarasoff* duty applies to outpatient settings, the same legal duty to protect individuals and society from harm by mental patients arises in the release of violent patients from hospitals. Generally, the scope of the duty to warn and protect is narrower than the duty not to release a violent patient. In court cases involving the failure to warn and protect an endangered third party, the threat of violence was serious and imminent, and the person was usually identifiable and a foreseeable victim.

The duty not to release a violent patient has a broader scope because violent patients often do not express specific threats toward persons or groups but still pose a threat to the general public. Thus in cases of negligent release, courts have occasionally ex-

tended the psychiatrist's duty beyond that owed to readily identifiable victims (37). Malpractice suits alleging negligent release exceed by five or six times the number of outpatient cases alleging a *Tarasoff* duty (38). Some states have passed immunity statutes limiting psychiatrists' responsibility for outpatients' violent acts (39). However, these statutes do not offer protection in cases of premature release.

Courts have traditionally used certain legal rationales to exculpate governmental agencies and psychotherapists from liability emanating from third-party injury as a result of voluntary release from a psychiatric hospital. These legal rationales include the standard of honest error or professional judgment, governmental and official immunity, lapse of time between release and injury to others, the balance between public safety and treatment of the mentally ill, unforeseeable harm, and the absence of a special relationship of the psychiatrist to either the patient or the victim of the patient (40). The legal liability of governmental agencies and therapists is expected to increase as deinstitutionalization continues and as courts find innovative ways to compensate victims of the violently mentally ill (41).

Conclusions

Treating potentially violent inpatients under managed care creates additional management duties and responsibilities. Psychiatrists continue to have a professional, ethical, and legal duty to provide competent care to patients in managed care settings. New obligations created by managed care organizations present a challenge to psychiatrists who are treating sicker and potentially violent inpatients. These same obligations, however, often can be turned into clinical opportunities that enhance the therapeutic alliance with the patient. ♦

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